RCA, What is the Process?

- A new and improved way of looking at **Adverse Events** or **Close Calls** including **Sentinel Events.**
- A process modeled after the NASA Aviation Safety Reporting System.
- A culture shift, a new way of helping to bring about a safer community for patients, employees, and visitors.
- A system that focus on processes rather than individual performance. RCA is not interested in whom, but rather in what and why. It is not a reporting system that is used for disciplinary action.
- It is a process based on the knowledge that:
  - Most errors come from faulty systems rather than human error.
  - Poorly designed processes set people up to make errors.
  - A process which produces a document (RCA) protected under the QM Confidentiality Provisions of Title 38, US Code Section 5705 and its implementing regulations.
  - A process that is strongly supported by senior management and your supervisor.

What Does This Mean For You?

- You may be called upon to participate as an RCA member. You will be looking for systems issues that were determined to have been the Root Cause or Contributing Cause of the adverse event you are charged to evaluate.
- You will receive "Just in Time Training" in RCA.
- You are responsible for reporting all adverse events or close calls to your supervisor or directly to your site Risk Manager or Safety Staff.

How Will You Benefit?

- You will learn new skills.
- You will receive educational credits towards your required 40 hours for the training.
- You will have the satisfaction of being part of a culture change, a new way of doing business. You will be making a difference.

Can I Get Involved Now, Or Do I Have To Wait To Be Called Upon?

If you would like to know more about this process and/or would like to participate by being a member of this core group, let your supervisor know, then contact your site Performance Management Office (PM/Risk Manager or Safety Staff).

DEFINITIONS:

Adverse Events:

Any situation(s) that has resulted in a negative outcome to any patient, visitor, or employee. This can also include environmental issues.

Close Calls:

Events or situations that could have resulted in an adverse event. These include accident, injury, or illness that did not occur because of chance or timely intervention. This category includes errors that could have had adverse consequences if only specifics of the situation had been different. Close calls are opportunities for learning and afford the chance to develop preventive strategies and actions. Close calls receive the same level of scrutiny as adverse events that result in an actual injury.

Sentinel Events:

As defined by the Joint Commission, sentinel is an unexpected death, or serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. Major permanent loss of function means sensory, motor, physiologic, or intellectual impairment not previously present that requires continued treatment or life-style change. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious outcomes. Other examples of sentinel event are:

- Suicide in a setting where 24-hour care is provided.
- Surgery on the wrong patient and/or wrong body part regardless of the magnitude of the operation.
- Hemolytic transfusion reaction involving the administration of blood or blood products having a major blood group incompatibilities.
- Infant abduction or discharge to wrong family.
- Rape by another patient or staff.

Root Cause is the most fundamental reason a problem has occurred. **Contributing Causes** are additional reasons a problem has occurred, but not necessarily the most basic reason.

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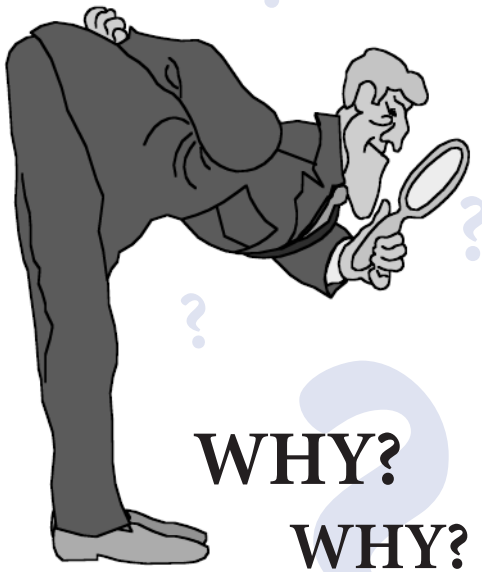
ROOT CAUSE ANALYSIS (RCA)



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